MEDICAID INFORMATION REPORT

Provider Participation:

Using Malpractice Insurance Assistance To Increase Access For The Medically Indigent

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Attached is a report entitled, "Provider Participation: Using Malpractice Insurance Assistance to Increase Access for the Medically Indigent." The report was prepared under a contract that the Medicaid Bureau has with the National Governors' Association. We hope that it will prove valuable in your work with the Medicaid program.

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Attachment

PROVIDER PARTICIPATION: USING MALPRACTICE INSURANCE ASSISTANCE TO INCREASE ACCESS FOR THE MEDICALLY INDIGENT

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PROVIDER PARTICIPATION: USING MALPRACTICE INSURANCE ASSISTANCE TO INCREASE ACCESS FOR THE MEDICALLY INDIGENT

Ensuring access to adequate health care for Medicaid recipients continues to be an elusive goal for states. While Medicaid provides a vehicle for the medically indigent to receive health services, there are several barriers that remain.

These barriers are viewed somewhat differently from the recipients' and the providers' perspectives. One of the most common complaints voiced by Medicaid recipients has been the problem of transportation to and from doctors' offices. Medicaid recipients also cite the inability to locate a provider that will accept Medicaid payment. When they do locate a Medicaid provider, the waiting time for an appointment and in the office is often excessive. Others find both the eligibility process, and repeated redetermination confusing and difficult to complete.

Providers view the barriers somewhat differently. Physicians argue that Medicaid payment is too low -- e.g., they lose money treating Medicaid recipients. Providers also cite complicated claims forms, delays in receiving payment, fear of being sued and the "hassle factor" -- as common reasons why they do not participate in Medicaid.

In recent years insufficient provider participation has been identified as an important barrier to care. Provider reluctance to perform obstetrics has posed a particular problem for pregnant women. Beginning in the early 1980s malpractice insurance premiums began increasing dramatically for providers who performed obstetrical services. As a result many providers were deterred from performing obstetrical care, particularly for Medicaid recipients. A large number of Medicaid providers ceased performing obstetrical procedures claiming the fees were not sufficient to offset malpractice premium costs. Further, the fear that indigent patients sue more frequently, although just the opposite has been found true, is often used to explain a providers unwillingness to serve Medicaid patients. Consequently pregnant women covered by Medicaid began finding access to health care difficult to achieve.

While accessing health care may be generally problematic for all Medicaid recipients, it is particularly difficult for individuals residing in rural communities. Rural communities commonly have difficulty attracting providers. Physicians tend to favor establishing lucrative practices in metropolitan areas. Due to a variety of reasons such as; large loan obligations, lower salary, lack of modern equipment, few colleagues with whom they can confer, and few employment opportunities for a spouse, physicians are much less likely to establish a practice in a rural community. While many states have programs which forgive or assist providers in repaying their loans, attracting a sufficient number of providers still remains a problem.

Due to the many interrelated issues surrounding physician participation in Medicaid, states that are undertaking the issue of provider participation are considering approaches that address a combination of problems. This issue brief will focus on one approach, establishing malpractice insurance assistance programs as incentives to encourage providers of obstetrical services to serve Medicaid recipients and other indigent populations.

In preparing this paper staff consulted with a wide range of organizations including: American College of Obstetricians and Gynecology, American Association of Trial Attorneys and several states' medical societies. Following that review, staff gathered information from state officials to get a clear understanding of their initiatives and available evaluative information. Evaluation of these initiatives is preliminary and tentative. This is due, in part, to the relative newness of these initiatives.

The State Response

Recognizing the decline in the number of providers of obstetrical care, and its effects on access, particularly for low income women, many states have sought ways to encourage physicians to continue to provide obstetrical care.

Tort Reform

Tort reform was a common strategy used by nearly every state during the 1980s. Approaches included: the formation of pre-trial panels and arbitration, establishing caps on damages, establishing statutes of limitations, limiting attorney fees, establishing standards of care, requiring structured settlements, developing catastrophic funds to cover settlements once the physician has paid a pre-determined amount, and general immunity "for volunteers," (persons who provide services at no charge) commonly know as good samaritan laws.

One strategy would cap claim settlements. A number of states established caps on the settlement amount, ranging from $100,000 to $500,000. These caps are intended to limit the liability of the provider to a pre-established dollar amount and prevent unreasonable claims against providers. The cap is intended to prevent plaintiffs from taking advantage of providers by suing for large, and it is argued, unreasonable sums of money.

Another strategy popular among states has been the restructuring of settlements. Intended to eliminate the possibility of excessive settlements levied on providers, this reform requires settlement payments to be made periodically, for a specified period of time, instead of in a lump sum payment.

Immunity for volunteers, known as good samaritan laws, prevent a volunteer or an individual acting as a good samaritan, from being sued. In general these provisions apply to the entire population in a state. However, many states have recently expanded the laws to include as samaritans providers who do not receive compensation for their services. Other states apply this type of protection to care provided in emergency situations.

While these measures have established a basic set of protections for providers, they have not been sufficient to significantly affect insurance premiums for obstetricians and consequently, the number of obstetricians participating in Medicaid. High malpractice premiums are clearly an issue that discourages providers due to the greater incidence of Medicaid recipients who are considered high-risk or more likely to deliver low-birth-weight babies, prone to developing disabilities and dysfunctions.

State Malpractice Insurance Assistance Programs

In recent years, while nearly every state has implemented some form of tort reform to encourage providers to continue to perform obstetrical services, this type of care is still particularly difficult to obtain. Although these reforms help to minimize the provider's exposure to liability damage they have done little to reduce obstetricians fear of suit or the premiums they pay for malpractice insurance.

In an effort to increase Medicaid provider participation, particularly for obstetrical care, many states have taken additional steps to increase the pool of obstetrical providers. These programs have taken a variety of forms. For example, in Virginia a fund was established to protect all obstetrical providers against suit for severe birth-related outcomes.

Thirteen states (AZ,FL,LA,ME,MD,MI,MS,NC,TX,TN,VA,WV,and WA) have established programs, separate from general tort reform, designed to increase the number of obstetrical providers. Some state's programs target only obstetrical care in rural areas and others target obstetrical care throughout the state. Still others are limited only to Medicaid and other indigent populations. In general malpractice assistance programs fall into three categories: insurance premium subsidies to providers, shifting the liability from the individual physician to the state when the provider is serving a Medicaid recipients or other indigent patients, and "no fault" funds which allow providers to buy into insurance coverage for protection against certain specified outcomes.

Subsidies to Providers

The most common state effort has been in the form of subsidy programs. In general these programs provide payment for a portion of a provider's malpractice premium as an incentive payment often related to the difference between malpractice liability insurance premiums for providing obstetrical care and not providing obstetrical care. Six states (AZ,MI,ME,NC,TN,WA) have established these programs.

Arizona has enacted two programs designed to increase the number of obstetrical providers. In 1989 the Arizona legislature passed the Support for Obstetrical Services Project, to develop a program for the purpose of paying additional medical malpractice premium costs for private physicians carrying their own liability coverage, and performing the delivery of infants at non-federal rural hospitals.

During the 1980's insurance companies in Arizona, following the national trend of increasing premiums for physicians who provided obstetrical care, began charging an additional premium for providers who delivered more than fifty babies.

Through this project, family physicians who perform fewer than fifty deliveries per year and who are required to pay an additional premium to perform obstetrical services shall be eligible to receive up to $5,000. Family physicians who perform more than fifty deliveries per year and who are required to pay an additional premium to perform obstetrical services shall be eligible to receive up to $10,000. Obstetricians who are required to pay an additional premium to perform obstetrical services will also be eligible for no more than $10,000. In the first year this program received $195,000 in appropriations and again in 1991 $200,000 was appropriated.

Legislation for a second malpractice subsidy program was passed in 1990 by the Arizona legislature. Because the earlier legislation required providers to carry their own liability coverage, providers working under contract to CHCs were not eligible. In an effort to assist CHCs, which were also feeling the burden of high malpractice premiums, the legislature created a fund to support Community Health Centers (CHC). In 1991 $200,000 was appropriated to offset malpractice costs. The funds are disbursed to CHCs based on the malpractice costs of the obstetricians, family practitioners and mid level practitioners providing obstetrical services in each center. While only five CHCs in the state presently provide obstetrical services, the program will allow additional centers to add obstetrical care and apply for the subsidy.

A different type of subsidy was established in Michigan. Michigan had a one year polit project which paid providers about $100 for each Medicaid delivery. It is important to note that this payment was earmarked to assist the provider in paying the malpractice premium. It was not a simple fee increase. Michigan chose specifically not to increase reimbursement to providers by the amount equal to the incentive payment. This strategy was well received and found to be more effective in attracting providers. However, due to budgetary constraints, funding was not available to continue the program.

Washington established a subsidy program to assist doctors who serve Medicaid and other indigents in paying malpractice premiums. In Washington the malpractice insurance carriers structured premiums so that family practice physicians who perform more than forty deliveries assume a greater premium expense. The state began subsidizing those providers to cover the additional costs of the insurance premium. While this subsidy program provided an additional incentive to enable some physicians to continue to participate in the Medicaid program the results were less than anticipated. The program was eliminated effective January 1, 1991 and replaced by substantial fees increases for obstetrical services.

Other states targeted subsidies to providers participating in specified geographic areas. The 1990 Maine Legislature established the Rural Medical Access Program to provide financial incentives to physicians practicing in underserved areas of the state to perform obstetrical services. To be eligible, a provider must: have professional liability insurance; be licensed in the state of Maine; accept and serve Medicaid patients; provide complete obstetrical care including prenatal care and delivery; and practice at least 50% of the time in areas of the state that are underserved areas for obstetrical and prenatal care as determined by the state Department of Human Services.

Through the Rural Medical Access program, physicians will receive an annual premium credit equal to the difference between the physician's medical malpractice insurance premiums with obstetrical care coverage and the premiums not including obstetrical care coverage. The credit ranges from a minimum of $5,000 to a maximum of $10,000.

The North Carolina Rural Obstetrical Care Incentive Program was established in 1989 to provide malpractice premium assistance to both physicians and nurse midwives in rural areas. The program received an increased appropriation from $240,000 in 1990 to $540,000 for 1991. As a result the state was able to fund the twenty-five original county grants for a total of $240,000 as well as an additional twenty-six counties, and fifty-five physicians with the newly appropriated $300,000.

To date forty-nine of the 100 counties in the state have applied for these funds. The Funds are disbursed to local health departments who submit approved applications. For each physician that contracts with the local health department, the health department will be paid the difference between the physician's premium with obstetrical coverage and without or $6,500, which ever is less. Payment will be based on a maximum of $1,000,000 liability coverage. The local health department will then pay this amount to the physician to cover a portion of the physician's annual malpractice premium. For nurse-midwives who contract with the local health department the health department will pay the lesser of the total amount of the nurse-midwife's premium or $3,000. Each underserved county can receive up to $19,500 in funds through this program.

The Tennessee Health Access Act of 1989 created a special account to provide liability insurance to providers serving medically underserved areas and populations. Under this program, a subsidy is provided to a family practice physician up to the amount of the differential in the premium for malpractice insurance with and without obstetrical services. This is available for both new providers of obstetrical care and those providers who are currently providing obstetrical care. The account is maintained through the proceeds from the sale of abandoned property. A portion of the account is used for these and other programs to improve access while the remainder maintains the body of the account.

State Assumes Liability

Five states, (MO, WV, MD, TX and LA) have established programs to either idemnify providers who serve Medicaid recipients or other medically-indigent populations or make them state employees when serving these populations. This allows the state to assume liability for the provider.

Missouri took advantage of its Legal Expense Fund, a self insurance fund provided by the state to cover liabilities of state employees, to expand access to obstetrical care. It now permits coverage of private physicians providing prenatal, delivery, or child care services under contract with a local health department. This program has resulted in two incentives to attract providers into continuing to provide obstetrical care; the fund not only eliminates a providers liability when serving this special population, it has created an atmosphere in which malpractice insurance carriers are inclined to reduce rates. One of the major carriers in the state has reduced premiums for physicians participating in the fund by $10,000-$15,000 a year. Additional carriers have contacted the state and are interested in learning more about the fund.

West Virginia recently established a liability program especially for malpractice coverage of obstetricians who serve Medicaid and other medically indigent. While the proposal passed the legislature, it did not receive sufficient funding. The lack of attention to this new plan is primarily due to a statewide liability pool which provides professional liability coverage for state employees. Nearly one-half of all obstetrical providers are covered under this pool. Providers who are under contract are considered state employees and as a result are covered through the statewide liability pool.

A new liability assistance program was recently established in Montgomery County, Maryland. Similar to statewide risk pools used in West Virginia and Missouri, the county employs physicians on a part-time basis to provide obstetrical services to Medicaid and other medically indigent and uninsured pregnant women.

The County pays the physicians an hourly rate, with a guaranteed minimum of eight hours per delivery. In addition to the payment received by the provider, the state assumes liability for any damages that may have resulted during that procedure. An unforeseen benefit of this program has been an agreement with the largest insurance carrier to exclude county patients from liability calculations for obstetrical providers who are county employees.

Different from most state indemnity laws, Texas' State Indemnification For Liability of Health Care Professionals is targeted at specific types of providers and providers who deliver at least 10 percent of their care to indigent populations. The Texas law applies to licensed physicians, licensed nurse practitioners, certified nurse midwives, and recognized physician assistants who are covered under a valid proessional liability insurance policy. The state is liable for indemnification under this chapter only if the damages are based on an eligible medical malpractice claim against a health care professional in the course and scope of that professionals health care activities. State liability under this legislation may not exceed $100,000 for a single occurrence in the case of an eligible medical malpractice claim arising as a result of prenatal care, care during labor and delivery, and care given to a mother or infant during the 30-day period immediately following delivery or as a result of emergency care. For any other eligible medical malpractice claim the state is liable for $25,000 for a single occurrence.

In addition to the liability protection these providers receive, they may also be eligible for an insurance premium discount. According to Article 5.15-4 of the Texas Insurance Code, providers who not only deliver 10 percent of the care they provide to indigent patients, but also complete 15 hours of continuing education on patient safety and risk reduction, during the term of policy, are eligible for a discount on their malpractice premium.

A similar program was recently signed into law by the Governor of Louisiana. The Health Care Access Act of 1990 creates a state indemnity pool for practitioners who provide at least 10 percent of their care as charity care under Medicaid or under contract with a public health center or Federally Qualified Health Centers (FQHCs). Somewhat different from Texas, which protects the provider for all care, physicians in Louisiana are protected only for the charity portion of their patient population. The State covers the first $100,000 of a judgement made as a result of prenatal care, care during delivery and post natal care for 30 days after delivery. Coverage for all other medical malpractice claims is limited to the first $25,000.

The law also provides for discounted liability premiums for physicians who devote at least 10% of their practice to charity care including services to medicaid recipients, maternal and child health programs and handicapped children's programs or as part of a contract or employment with a public health center or FQHC.

No Fault Funds

Three states (FL, VA and LA) have enacted legislation which provides no-fault coverage for obstetrical providers. In general these funds require a contribution from providers in order to receive liability protection from suit based on specific birth-related outcomes.

In 1987 Virginia became the first state to establish a no-fault liability fund for coverage of birth-related neurological injuries to newborns. Every licensed physician in the state is required to make a nominal contribution to the fund. To receive liability protection against infants delivered with birth-related neurological disorders, providers of obstetrical services pay an annual fee of approximately $5,000. Hospitals can also receive the same liability coverage. The hospital payment is based on the number of deliveries performed the previous year. There is a ten year statute of limitations.

In 1988 the Florida legislature followed suit by establishing the No-Fault Fund For Severely Injured babies. The fund allows providers to buy coverage for protection against the liability of delivering a severely injured baby. Each provider pays $5,000 per year. Hospitals also may participate. They are required to contribute $50 per infant delivered during the previous calendar year. The fund covers the victim's actual expenses for medical, hospital, rehabilitative, residential and custodial care. In addition the patient's parents may receive periodic payments up to $100,000.

Established in 1975, the Louisiana Patient Compensation Fund provides malpractice coverage for providers who contribute to the fund. Different from the Florida and Virginia programs, in Louisiana the physician is liable for the first $100,000, the fund then covers judgements of up to $500,000 plus all

medical expenses and trial costs. The physician's contribution to the fund is a flat fee based on specialty. In addition to the extra protection the fund provides, members are also protected by the state's limited liability law. Providers who are not part of the Patient Compensation Fund are subject to unlimited liability should a suit be brought against them.

Conclusion

All the approaches states have implemented create incentives to physicians to provide obstetrical services to the Medicaid population and other medically indigent individuals. However, the real question remains unanswered as yet. Do no fault programs, insurance subsidies and provider immunity programs encourage sufficient numbers of providers to perform obstetrical services to underserved populations? Perhaps more important, do these programs encourage enough providers to participate that it helps achieve the ultimate goals of improved access and better outcomes?

If the goal of increasing participation is to improve access for the medically indigent, public policy should be certain that a sufficient number of providers are available; but also to ensure that recipients can gain access to these providers. Problems with transportation and child care are often the reason many patients are unable to keep appointments. Considerations such as these need to be taken into account when developing strategies to improve access for the Medicaid population.

Clearly medical malpractice liability is only one piece of the access puzzle. In addition to providing incentives for providers of obstetrical care to continue this care for Medicaid recipients, states are actively pursuing other means such as increasing fees and simplifying the claims process. Combining a variety of approaches, which take into consideration the needs of both the provider and the recipient, is likely to be the best way states can attract the largest number of providers and, in turn, improve access for the medically indigent.

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For further information or clarification of material presented in this narrative, please contact Amanda H. McCloskey at (202) 624-5349.